

REFERENCE TITLE: health care; high risk program

State of Arizona
House of Representatives
Forty-eighth Legislature
Second Regular Session
2008

HB 2840

Introduced by
Representatives Adams, Driggs, Murphy

AN ACT

AMENDING SECTIONS 20-224 AND 20-224.05, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-846; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1079; AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1383; AMENDING SECTION 36-2930, ARIZONA REVISED STATUTES; AMENDING TITLE 36, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 38; AMENDING SECTION 43-210, ARIZONA REVISED STATUTES; PROVIDING FOR THE DELAYED REPEAL OF SECTIONS 20-2330, 36-2912, 36-2912.01, 36-2912.02 AND 36-2912.03, ARIZONA REVISED STATUTES; AMENDING LAWS 2007, CHAPTER 263, SECTIONS 30 AND 35; RELATING TO THE HEALTHCARE GROUP HIGH RISK PROGRAM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 20-224, Arizona Revised Statutes, is amended to read:

20-224. Premium tax

A. On or before March 1 of each year, each authorized domestic insurer, each other insurer and each formerly authorized insurer referred to in section 20-206, subsection B, ~~shall~~ shall file with the director a report in a form prescribed by the director showing total direct premium income including policy membership and other fees and all other considerations for insurance from all classes of business whether designated as a premium or otherwise received by it during the preceding calendar year on account of policies and contracts covering property, subjects or risks located, resident or to be performed in this state, after deducting from such total direct premium income applicable cancellations, returned premiums, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer and all policy dividends, refunds, savings coupons and other similar returns paid or credited to policyholders within this state and not reapplied as premiums for new, additional or extended insurance. No deduction shall be made of the cash surrender values of policies or contracts. Considerations received on annuity contracts, as well as the unabsorbed portion of any premium deposit, shall not be included in total direct premium income, and neither shall be subject to tax. The report shall separately indicate the total direct premium income received from fire insurance premiums on property located in an incorporated city or town that procures the services of a private fire company.

B. Coincident with the filing of such tax report each insurer shall pay to the director for deposit, pursuant to sections 35-146 and 35-147, a tax of 2.0 per cent of such net premiums, except that the tax on fire insurance premiums on property located in an incorporated city or town which procures the services of a private fire company is .66 per cent, the tax on all other fire insurance premiums is 2.2 per cent and the tax on health care service and disability insurance premiums is as prescribed under sections 20-837, 20-1010 and 20-1060. Any payments of tax pursuant to subsection E of this section shall be deducted from the tax payable pursuant to this subsection. Each insurer shall reflect the cost savings attributable to the lower tax in fire insurance premiums charged on property located in an incorporated city or town that procures the services of a private fire company.

C. Eighty-five per cent of the tax paid ~~hereunder~~ UNDER THIS SECTION by an insurer on account of premiums received for fire insurance shall be separately specified in the report and shall be apportioned in the manner provided by sections 9-951, 9-952 and 9-972, except that all of the tax so allocated to a fund of a municipality which has no volunteer fire fighters or pension obligations to volunteer fire fighters shall be appropriated to the

1 account of the municipality in the public safety personnel retirement system
 2 and all of the tax so allocated to a fund of a municipality which has both
 3 full-time paid fire fighters and volunteer fire fighters or pension
 4 obligations to full-time paid fire fighters or volunteer fire fighters shall
 5 be appropriated to the account of the municipality in the public safety
 6 personnel retirement system where it shall be reallocated by actuarial
 7 procedures proportionately to the municipality for the account of the
 8 full-time paid fire fighters and to the municipality for the account of the
 9 volunteer fire fighters. A full accounting of such reallocation shall be
 10 forwarded to the municipality and both local boards.

11 D. This section shall not apply to title insurance, and such insurers
 12 shall be taxed as provided in section 20-1566.

13 E. Any insurer which paid or is required to pay a tax of two thousand
 14 dollars or more on net premiums received during the preceding calendar year,
 15 pursuant to subsection B of this section and sections 20-224.01, 20-837,
 16 20-1010, 20-1060 and 20-1097.07, shall file on or before the fifteenth day of
 17 each month from March through August a report for that month, on a form
 18 prescribed by the director, accompanied by a payment in an amount equal to
 19 fifteen per cent of the amount paid or required to be paid during the
 20 preceding calendar year pursuant to subsection B of this section and sections
 21 20-224.01, 20-837, 20-1010, 20-1060 and 20-1097.07. The payments are due and
 22 payable on or before the fifteenth day of each month and shall be made to the
 23 director for deposit, pursuant to sections 35-146 and 35-147.

24 F. THE STATE TREASURER SHALL CALCULATE THE TOTAL AMOUNT OF NET PREMIUM
 25 TAX COLLECTED FOR CALENDAR YEAR 2008. BEGINNING MARCH 1, 2010 AND EACH MARCH
 26 1 THEREAFTER, THE STATE TREASURER SHALL DETERMINE THE INCREASE FROM THE
 27 PREVIOUS CALENDAR YEAR ON NET PREMIUM TAX COLLECTED FROM CALENDAR YEAR 2008
 28 AND DEPOSIT THOSE MONIES IN THE HEALTHCARE GROUP HIGH RISK PROGRAM FUND
 29 ESTABLISHED BY SECTION 36-3814.

30 ~~F.~~ G. Except for the tax paid on fire insurance premiums pursuant to
 31 subsections B and C of this section, an insurer may claim a premium tax
 32 credit if the insurer qualifies for a credit pursuant to section 20-224.03 or
 33 20-224.04.

34 Sec. 2. Section 20-224.05, Arizona Revised Statutes, is amended to
 35 read:

36 20-224.05. Premium tax credit for health insurance certificates
 37 submitted by qualified persons; definitions

38 A. From and after December 31, 2006, an annual tax credit is allowed
 39 against the premium tax liability incurred by a health care insurer pursuant
 40 to section 20-224, 20-837 or 20-1060 for an individual or a small business
 41 that has received a certificate from the department of revenue pursuant to
 42 section 43-210 and obtained health insurance from a health care insurer
 43 within ninety days after the date the certificate was issued.

1 B. The maximum amount of tax credits allowed under this section shall
2 not exceed the aggregate amount of certificates approved by the department of
3 revenue pursuant to section 43-210.

4 C. For coverage issued to an individual, the amount of the credit is
5 the lesser of:

6 1. One thousand dollars for coverage on a single person, five hundred
7 dollars for coverage on a child or three thousand dollars for family
8 coverage.

9 2. Fifty per cent of the health insurance premium.

10 D. For coverage issued to a small business, the amount of the credit
11 is the lesser of:

12 1. One thousand dollars for coverage on a single person or three
13 thousand dollars for each employee who elects family coverage.

14 2. Fifty per cent of the health insurance premium.

15 E. If the allowable tax credit exceeds the state premium tax
16 liability, the amount of the claim not used as an offset against the state
17 premium tax liability may be carried forward as a tax credit against
18 subsequent years' state premium tax liability for a period not to exceed five
19 taxable years or refunded as allowed under section 20-224.02.

20 F. The department may adopt rules necessary for the administration of
21 this section.

22 G. A health care insurer allowed a credit against its premium tax
23 liability under this section shall not be required to pay any additional
24 retaliatory tax levied pursuant to section 20-230 as a result of claiming the
25 credit.

26 H. For the purposes of this section:

27 1. "Family" means any of the following:

28 (a) An adult and the adult's spouse.

29 (b) An adult, the adult's spouse and all unmarried dependent children
30 under nineteen years of age or under twenty-five years of age if a full-time
31 student.

32 (c) An adult and the adult's unmarried dependent children under
33 nineteen years of age or under twenty-five years of age if a full-time
34 student.

35 2. "Health care insurer" means a disability insurer, group disability
36 insurer, blanket disability insurer, health care services organization,
37 hospital service corporation, medical service corporation or hospital,
38 medical, dental and optometric service corporation that provides health
39 insurance in this state.

40 3. "Health insurance" means a licensed health care plan or arrangement
41 that pays for or furnishes medical or health care services and that is issued
42 by a health care insurer. Health insurance does not include limited benefit
43 coverage as defined in section 20-1137.

1 4. "Small business" means EITHER:

2 (a) A business that has been in existence for at least one calendar
3 year in this state, that has not provided health insurance to its employees
4 for at least six months and that had between two and twenty-five employees
5 during the most recent calendar year.

6 (b) BEGINNING JANUARY 1, 2010, A SMALL GROUP OF TWO TO FIFTY
7 EMPLOYEES, OTHER THAN A POLITICAL SUBDIVISION OF THIS STATE, THAT WAS
8 ENROLLED IN HEALTHCARE GROUP OF ARIZONA AS OF JANUARY 1, 2010.

9 Sec. 3. Title 20, chapter 4, article 3, Arizona Revised Statutes, is
10 amended by adding section 20-846, to read:

11 20-846. Participation in healthcare group high risk program;
12 enforcement

13 A. A HOSPITAL AND MEDICAL SERVICE CORPORATION OR A HOSPITAL, MEDICAL,
14 OPTOMETRIC AND DENTAL SERVICE CORPORATION THAT ISSUES NONGROUP COVERAGE SHALL
15 PARTICIPATE IN THE HEALTHCARE GROUP HIGH RISK PROGRAM ESTABLISHED BY TITLE
16 36, CHAPTER 38 AND IS SUBJECT TO THE REQUIREMENTS OF THAT PROGRAM THAT APPLY
17 TO INSURERS.

18 B. THE DIRECTOR SHALL ENFORCE THIS SECTION AND, ON NOTIFICATION BY THE
19 HEALTHCARE GROUP BOARD THAT A HOSPITAL AND MEDICAL SERVICE CORPORATION OR A
20 HOSPITAL, MEDICAL, OPTOMETRIC AND DENTAL SERVICE CORPORATION IS NOT IN
21 COMPLIANCE WITH THE HEALTHCARE GROUP HIGH RISK PROGRAM REQUIREMENTS, SHALL
22 INVESTIGATE THE ALLEGATION AND, IF APPROPRIATE, TAKE DISCIPLINARY ACTION
23 AGAINST THE HOSPITAL AND MEDICAL SERVICE CORPORATION OR HOSPITAL, MEDICAL,
24 OPTOMETRIC AND DENTAL SERVICE CORPORATION.

25 Sec. 4. Title 20, chapter 4, article 9, Arizona Revised Statutes, is
26 amended by adding section 20-1079, to read:

27 20-1079. Participation in healthcare group high risk program;
28 enforcement

29 A. A HEALTH CARE SERVICES ORGANIZATION THAT ISSUES NONGROUP COVERAGE
30 SHALL PARTICIPATE IN THE HEALTHCARE GROUP HIGH RISK PROGRAM ESTABLISHED BY
31 TITLE 36, CHAPTER 38 AND IS SUBJECT TO THE REQUIREMENTS OF THAT PROGRAM THAT
32 APPLY TO INSURERS.

33 B. THE DIRECTOR SHALL ENFORCE THIS SECTION AND, ON NOTIFICATION BY THE
34 HEALTHCARE GROUP BOARD THAT A HEALTH CARE SERVICES ORGANIZATION IS NOT IN
35 COMPLIANCE WITH THE HEALTHCARE GROUP HIGH RISK PROGRAM REQUIREMENTS, SHALL
36 INVESTIGATE THE ALLEGATION AND, IF APPROPRIATE, TAKE DISCIPLINARY ACTION
37 AGAINST THE HEALTH CARE SERVICES ORGANIZATION.

38 Sec. 5. Title 20, chapter 6, article 4, Arizona Revised Statutes, is
39 amended by adding section 20-1383, to read:

40 20-1383. Participation in healthcare group high risk program;
41 enforcement

42 A. A DISABILITY INSURER THAT ISSUES NONGROUP COVERAGE SHALL
43 PARTICIPATE IN THE HEALTHCARE GROUP HIGH RISK PROGRAM ESTABLISHED BY TITLE
44 36, CHAPTER 38 AND IS SUBJECT TO THE REQUIREMENTS OF THAT PROGRAM THAT APPLY
45 TO INSURERS.

1 B. THE DIRECTOR SHALL ENFORCE THIS SECTION AND, ON NOTIFICATION BY THE
2 HEALTHCARE GROUP BOARD THAT A DISABILITY INSURER IS NOT IN COMPLIANCE WITH
3 THE HEALTHCARE GROUP HIGH RISK PROGRAM REQUIREMENTS, SHALL INVESTIGATE THE
4 ALLEGATION AND, IF APPROPRIATE, TAKE DISCIPLINARY ACTION AGAINST THE
5 DISABILITY INSURER.

6 Sec. 6. Section 36-2930, Arizona Revised Statutes, is amended to read:

7 36-2930. Temporary medical coverage program; qualifications;
8 fund; program termination

9 A. The temporary medical coverage program is established. Beginning
10 October 1, 2006, the administration shall establish eligibility for the
11 program for any uninsured person who meets the following requirements:

12 1. Is a resident of this state.

13 2. Is a citizen of the United States or a legal resident that meets
14 the requirements of section 36-2903, subsection B or C.

15 3. Submits an application as prescribed by the administration.

16 4. Has been eligible for services pursuant to section 36-2901,
17 paragraph 6 or section 36-2931, paragraph 5 and enrolled in the system,
18 ~~excluding persons who are receiving services pursuant to section 36-2912,~~ at
19 any time within twenty-four months before the person submits an application
20 pursuant to paragraph 3 of this subsection.

21 5. Is receiving benefits pursuant to 42 United States Code
22 section 423.

23 6. Is not eligible for medicare benefits pursuant to 42 United States
24 Code section 426(b) or section 426-1.

25 B. The director may adopt rules to implement the program and the
26 requirements of this section and to prescribe the following:

27 1. The application process.

28 2. Actuarially sound capitation rates.

29 3. The collection of monthly premiums from program enrollees. Monthly
30 premiums shall not exceed the capitation rate paid to health plans for the
31 enrollee and shall be based on the enrollee's gross household income with
32 tiered premiums for any enrollee whose income is:

33 (a) More than one hundred but not more than one hundred fifty per cent
34 of the federal poverty guidelines.

35 (b) More than one hundred fifty but not more than two hundred per cent
36 of the federal poverty guidelines.

37 (c) More than two hundred but not more than two hundred fifty per cent
38 of the federal poverty guidelines.

39 (d) More than two hundred fifty but not more than three hundred per
40 cent of the federal poverty guidelines.

41 (e) More than three hundred per cent of the federal poverty
42 guidelines.

43 C. All covered services shall be provided by health plans that have
44 contracts with the administration pursuant to section 36-2906.

D. Unless otherwise required by the administration, the health plans shall provide medically necessary health and medical services as required by section 36-2907.

E. A person who is enrolled in the program must notify the administration when the person becomes eligible for medicare benefits through 42 United States Code section 426(b) or section 426-1. A person who is enrolled in the program and who becomes eligible for medicare benefits is ineligible for the program.

F. If the director determines that monies may be insufficient for the program, the administration may stop processing applications until the administration is able to verify that funding is sufficient to fund the program.

G. The temporary medical coverage fund is established consisting of premiums collected from enrollees pursuant to subsection B of this section, gifts, grants and donations received by the administration to operate the program. The administration shall use fund monies to pay for the services and costs associated with persons who are eligible pursuant to this section. On notice from the administration, the state treasurer shall invest and divest monies in the fund as provided by section 35-313, and monies earned from investment shall be credited to the fund. Monies in the fund are subject to legislative appropriation.

H. The program established by this section ends on July 1, 2016 pursuant to section 41-3102.

Sec. 7. Title 36, Arizona Revised Statutes, is amended by adding chapter 38, to read:

CHAPTER 38

HEALTHCARE GROUP HIGH RISK PROGRAM

ARTICLE 1. GENERAL PROVISIONS

36-3801. Definitions

IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "ADMINISTRATION" MEANS THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

2. "ADMINISTRATOR" MEANS THE ADMINISTRATOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

3. "BOARD" MEANS THE BOARD OF DIRECTORS OF THE HEALTHCARE GROUP HIGH RISK PROGRAM.

4. "DIRECTOR" MEANS THE DIRECTOR OF THE ADMINISTRATION.

5. "INSURER" MEANS A HOSPITAL AND MEDICAL SERVICE CORPORATION, HOSPITAL, MEDICAL, OPTOMETRIC AND DENTAL SERVICE CORPORATION, HEALTH CARE SERVICES ORGANIZATION OR DISABILITY INSURER THAT IS AUTHORIZED TO TRANSACT INSURANCE PURSUANT TO TITLE 20 AND ISSUES NONGROUP COVERAGE.

6. "NONGROUP COVERAGE" MEANS COVERAGE THAT IS SOLD IN THE INDIVIDUAL MARKET AND THAT IS PURCHASED BY AN INDIVIDUAL FOR THE INDIVIDUAL'S AND THE INDIVIDUAL'S DEPENDENT'S HEALTH CARE COVERAGE.

1 7. "POLICY" MEANS AN EVIDENCE OF COVERAGE, SUBSCRIPTION CONTRACT OR
2 POLICY ISSUED BY AN INSURER TO AN ELIGIBLE INDIVIDUAL.

3 8. "PRODUCER" MEANS AN INSURANCE PRODUCER LICENSED UNDER TITLE 20,
4 CHAPTER 2, ARTICLE 3.

5 9. "PROGRAM" MEANS THE HEALTHCARE GROUP HIGH RISK PROGRAM.

6 10. "STANDARD RATE" MEANS THE IN FORCE RATE OFFERED TO SIMILARLY
7 SITUATED NONPARTICIPANTS IN THE INDIVIDUAL MARKET WHO HAVE THE SAME
8 DEMOGRAPHIC AND NONHEALTH RELATED STATUS CHARACTERISTICS.

9 11. "SYSTEM" MEANS THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
10 ESTABLISHED BY CHAPTER 29, ARTICLE 1 OF THIS TITLE.

11 36-3802. Healthcare group; purposes

12 HEALTHCARE GROUP IS ESTABLISHED IN THE SYSTEM FOR THE FOLLOWING
13 PURPOSES:

14 1. TO ASSIST THE PREMIUM TAX CREDIT PROGRAM ESTABLISHED BY SECTIONS
15 20-224.05 AND 43-210.

16 2. TO ASSIST THE HEALTHCARE GROUP HIGH RISK PROGRAM.

17 36-3803. Premium tax credit program report

18 A. THE ADMINISTRATION SHALL PROMOTE THE PREMIUM TAX CREDIT PROGRAM
19 ESTABLISHED BY SECTION 43-210 TO INDIVIDUALS WHO DO NOT QUALIFY FOR SERVICES
20 PROVIDED BY THE ADMINISTRATION.

21 B. IN COOPERATION WITH THE DEPARTMENT OF REVENUE AND THE DEPARTMENT OF
22 INSURANCE, THE ADMINISTRATION SHALL SUBMIT A REPORT TO THE PRESIDENT OF THE
23 SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES EACH JUNE 1 CONCERNING
24 THE PREMIUM TAX CREDIT PROGRAM AND PROVIDE A COPY OF THIS REPORT TO THE
25 SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES
26 AND PUBLIC RECORDS. THE REPORT SHALL CONTAIN THE FOLLOWING INFORMATION:

27 1. THE NUMBER OF SMALL BUSINESSES AND INDIVIDUALS WHO OBTAINED A
28 CERTIFICATE OF ELIGIBILITY FROM THE DEPARTMENT OF REVENUE.

29 2. A REVIEW OF THE PREMIUMS CHARGED BY HEALTH CARE INSURERS FOR EACH
30 CERTIFICATE OF ELIGIBILITY.

31 3. AN ANALYSIS OF CLIENT SATISFACTION.

32 4. THE AVERAGE ANNUAL INCOME OF INDIVIDUALS WHO OBTAINED A CERTIFICATE
33 OF ELIGIBILITY.

34 5. THE AVERAGE PREMIUM CHARGED BY HEALTH CARE INSURERS.

35 6. OTHER INFORMATION NECESSARY TO ANALYZE AND EVALUATE THE IMPACT ON
36 THE ACCESSIBILITY OF OBTAINING HEALTH INSURANCE FOR SMALL BUSINESSES AND
37 INDIVIDUALS AS A RESULT OF THE PREMIUM TAX CREDIT PROGRAM.

38 36-3804. Healthcare group high risk program; board of
39 directors; appointment; terms

40 A. THE HEALTHCARE GROUP HIGH RISK PROGRAM IS ESTABLISHED IN THE
41 SYSTEM.

42 B. THE PROGRAM OPERATES UNDER THE SUPERVISION AND CONTROL OF A BOARD
43 OF DIRECTORS. THE BOARD CONSISTS OF THE FOLLOWING MEMBERS:

44 1. TWO NONVOTING MEMBERS, WHO ARE NOT COUNTED FOR DETERMINING A
45 QUORUM, CONSISTING OF:

- 1 (a) THE DIRECTOR OF THE ADMINISTRATION.
2 (b) THE DIRECTOR OF THE DEPARTMENT OF INSURANCE.
3 2. SEVEN VOTING MEMBERS, WHO ARE APPOINTED BY THE GOVERNOR, CONSISTING
4 OF:
5 (a) FOUR MEMBERS WHO REPRESENT INSURERS, ONE OF WHOM MUST BE AN
6 ACTUARY.
7 (b) ONE MEMBER WHO REPRESENTS PRODUCERS.
8 (c) ONE MEMBER WHO REPRESENTS THE PUBLIC.
9 (d) ONE MEMBER WHO REPRESENTS HEALTH CARE PROVIDERS.
10 C. VOTING BOARD MEMBERS SERVE FIVE-YEAR TERMS. MEMBERS OF THE BOARD
11 SHALL ELECT A CHAIRPERSON AND A COCHAIRPERSON.
12 D. VOTING BOARD MEMBERS ARE NOT ELIGIBLE TO RECEIVE COMPENSATION BUT
13 ARE ELIGIBLE FOR REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4,
14 ARTICLE 2.
15 36-3805. Plan of operation
16 A. THE BOARD SHALL ADOPT A PLAN OF OPERATION FOR THE PROGRAM AND ANY
17 AMENDMENTS TO THE PLAN.
18 B. THE PLAN OF OPERATION SHALL PRESCRIBE:
19 1. OPERATING PROCEDURES.
20 2. PROCEDURES FOR REIMBURSING INSURERS FOR CLAIMS OF PROGRAM
21 PARTICIPANTS.
22 3. PROCEDURES FOR THE HANDLING, ACCOUNTING AND AUDITING OF ASSETS,
23 MONIES AND CLAIMS OF THE PLAN.
24 4. THE DEVELOPMENT AND IMPLEMENTATION OF A PROGRAM TO CREATE AND
25 MAINTAIN PUBLIC AWARENESS OF THE PLAN.
26 5. PROCEDURES UNDER WHICH A GRIEVANCE COMMITTEE THAT IS APPOINTED BY
27 THE BOARD MAY REVIEW GRIEVANCES OF AN APPLICANT OR PARTICIPANT. THE
28 GRIEVANCE COMMITTEE SHALL REPORT THE GRIEVANCES TO THE BOARD AFTER COMPLETION
29 OF THE REVIEW. THE BOARD SHALL RETAIN ALL WRITTEN COMPLAINTS REGARDING THE
30 PLAN FOR AT LEAST THREE YEARS.
31 6. OTHER MATTERS THAT MAY BE NECESSARY AND PROPER FOR THE EXECUTION OF
32 THE BOARD'S POWERS, DUTIES AND OBLIGATIONS.
33 36-3806. Powers and duties of the board; annual report;
34 immunity
35 A. THE BOARD HAS THE GENERAL POWERS AND AUTHORITY GRANTED UNDER THE
36 LAWS OF THIS STATE TO HEALTH INSURERS, EXCEPT ISSUING POLICIES OF INSURANCE,
37 AND THE SPECIFIC AUTHORITY TO:
38 1. CARRY OUT THE PROVISIONS AND PURPOSES OF THE PLAN, INCLUDING THE
39 AUTHORITY TO ENTER INTO CONTRACTS WITH PERSONS OR OTHER ORGANIZATIONS FOR THE
40 PERFORMANCE OF ADMINISTRATIVE FUNCTIONS.
41 2. SUE OR BE SUED, INCLUDING ANY LEGAL ACTION TO:
42 (a) AVOID REIMBURSING IMPROPER CLAIMS.
43 (b) RECOVER ANY AMOUNTS THE PLAN ERRONEOUSLY OR IMPROPERLY PAID.
44 (c) RECOVER OTHER AMOUNTS DUE THE PLAN.

1 3. ESTABLISH AND MODIFY CLAIM RESERVE FORMULAS AND ANY OTHER ACTUARIAL
2 FUNCTION THAT ARE APPROPRIATE TO THE OPERATION OF THE PLAN.

3 4. ESTABLISH ACCOUNTS AS NECESSARY TO ADMINISTER THE PROGRAM AND
4 REIMBURSE INSURERS FOR CLAIM PAYMENTS.

5 5. APPOINT APPROPRIATE LEGAL, ACTUARIAL AND OTHER COMMITTEES AS
6 NECESSARY TO PROVIDE TECHNICAL ASSISTANCE IN THE OPERATION OF THE PLAN.

7 6. BORROW MONEY TO EFFECT THE PURPOSES OF THE PLAN. ANY NOTES OR
8 OTHER EVIDENCES OF INDEBTEDNESS OF THE PLAN THAT ARE NOT IN DEFAULT ARE LEGAL
9 INVESTMENTS FOR INSURERS AND MAY BE CARRIED AS ADMITTED ASSETS.

10 7. PROVIDE FOR REINSURANCE OF RISKS INCURRED BY THE PLAN AND ESTABLISH
11 RULES, CONDITIONS AND PROCEDURES FOR REINSURING RISKS.

12 8. EMPLOY AND DETERMINE THE CONDITIONS OF EMPLOYMENT AND DUTIES OF THE
13 EMPLOYEES. EMPLOYEE COMPENSATION SHALL BE AS PRESCRIBED IN SECTION 38-611.
14 PLAN EMPLOYEES ARE EMPLOYEES OF THE ADMINISTRATION. THE BOARD SHALL PAY
15 THEIR SALARIES AND RELATED EXPENSES OUT OF THE HEALTHCARE GROUP HIGH RISK
16 PROGRAM FUND.

17 9. ADOPT BYLAWS, POLICIES AND PROCEDURES AS NECESSARY OR CONVENIENT
18 FOR THE IMPLEMENTATION AND OPERATION OF THE PLAN.

19 10. PRESCRIBE RATES FOR THE UNDERLYING POLICIES PURSUANT TO SECTION
20 36-3810.

21 11. ESTABLISH A RESOLUTION PROCESS FOR CLAIMS REIMBURSEMENT DISPUTES
22 WITH INSURERS.

23 12. DEVELOP AND IMPLEMENT AN ELECTRONIC CLAIMS SUBMISSION PROCESS.

24 13. REPORT INSURER NONCOMPLIANCE TO THE DIRECTOR OF THE DEPARTMENT OF
25 INSURANCE.

26 14. ENTER INTO CONTRACTS WITH INSURERS TO ADMINISTER THE PROGRAM
27 POLICIES. THE CONTRACT SHALL CLEARLY DEFINE THE RESPONSIBILITIES OF THE
28 BOARD AND THE INSURER.

29 15. SEEK FEDERAL MONIES FOR HIGH RISK POOL START-UP AND MAINTENANCE
30 COSTS.

31 B. ON OR BEFORE JUNE 30, THE BOARD SHALL SUBMIT AN ANNUAL REPORT TO
32 THE GOVERNOR, THE PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE OF
33 REPRESENTATIVES AND THE DIRECTOR OF THE ADMINISTRATION AND SHALL PROVIDE
34 COPIES TO THE SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE
35 LIBRARY, ARCHIVES AND PUBLIC RECORDS. THE REPORT SHALL SUMMARIZE THE
36 ACTIVITIES OF THE BOARD IN THE PRECEDING CALENDAR YEAR, INCLUDING THE NUMBER
37 OF PARTICIPATING INSURERS AND INDIVIDUALS, CLAIMS PAID, EXPENSE OF
38 ADMINISTRATION AND PAID AND INCURRED LOSSES.

39 C. THE BOARD AND THE BOARD'S EMPLOYEES ARE NOT LIABLE FOR ANY
40 OBLIGATIONS OF THE PLAN. A MEMBER OR EMPLOYEE OF THE BOARD IS NOT LIABLE AND
41 NO CAUSE OF ACTION OF ANY NATURE MAY ARISE AGAINST THE MEMBER OR EMPLOYEE FOR
42 ANY ACT OR OMISSION RELATED TO THE PERFORMANCE OF THE POWERS AND DUTIES
43 PRESCRIBED IN THIS CHAPTER UNLESS THE ACT OR OMISSION CONSTITUTES WILFUL OR
44 WANTON MISCONDUCT. THE BOARD MAY PROVIDE IN ITS BYLAWS OR RULES FOR
45 INDEMNIFICATION OF AND LEGAL REPRESENTATION FOR ITS MEMBERS AND EMPLOYEES.

1 36-3807. Eligibility: board notification: participant card

2 A. AN INDIVIDUAL IS ELIGIBLE FOR PARTICIPATION IN THE HEALTHCARE GROUP
3 HIGH RISK PROGRAM IF THE INDIVIDUAL IS AND CONTINUES TO BE A LEGAL RESIDENT
4 OF THIS STATE AND ANY OF THE FOLLOWING APPLY:

5 1. BEGINNING JANUARY 1, 2010, THE INDIVIDUAL WAS A MEMBER OF
6 HEALTHCARE GROUP OF ARIZONA AS OF JANUARY 1, 2010.

7 2. BEGINNING JANUARY 1, 2011, THE INDIVIDUAL PROVIDES EVIDENCE OF
8 REJECTION OR REFUSAL TO ISSUE HEALTH INSURANCE FOR HEALTH REASONS BY AN
9 INSURER IN THIS STATE WITHIN THE PAST YEAR. A REJECTION OR REFUSAL BY AN
10 INSURER THAT OFFERS ONLY LIMITED BENEFIT COVERAGE, AS DEFINED IN SECTION
11 20-1137, STOP LOSS, EXCESS OF LOSS OR REINSURANCE COVERAGE WITH RESPECT TO
12 THE APPLICANT IS NOT SUFFICIENT EVIDENCE OF REJECTION OR REFUSAL. AN INSURER
13 THAT REJECTS OR REFUSES TO ISSUE HEALTH INSURANCE TO AN APPLICANT SHALL
14 INFORM THE APPLICANT OF THE HEALTHCARE GROUP HIGH RISK PROGRAM AND PRESENT
15 THE APPLICANT INFORMATION ABOUT THE INSURER'S HIGH RISK POLICIES AND PREMIUMS
16 FOR THOSE POLICIES. THE INDIVIDUAL MAY OBTAIN PROGRAM COVERAGE FROM THAT
17 INSURER OR ANY OTHER INSURER.

18 3. BEGINNING JANUARY 1, 2011, SECTION 35 OF THE INTERNAL REVENUE CODE
19 OF 1986.

20 4. BEGINNING JANUARY 1, 2011, ELIGIBILITY CRITERIA PRESCRIBED IN THE
21 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191;
22 110 STAT. 1936) AND ANY FEDERAL REGULATIONS ADOPTED TO IMPLEMENT THE HEALTH
23 INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.

24 B. BEGINNING JANUARY 1, 2010, AN INSURER SHALL ISSUE COVERAGE TO AN
25 INDIVIDUAL WHO IS ELIGIBLE FOR COVERAGE PURSUANT TO SUBSECTION A OF THIS
26 SECTION.

27 C. ON ISSUING A POLICY, SUBSCRIPTION CONTRACT OR EVIDENCE OF COVERAGE
28 TO AN INDIVIDUAL WHO IS ELIGIBLE PURSUANT TO SUBSECTION A OF THIS SECTION,
29 THE INSURER SHALL PROVIDE THE FOLLOWING INFORMATION TO THE BOARD:

30 1. THE NAME OF THE PARTICIPANT.

31 2. THE PLAN THE PARTICIPANT SELECTS.

32 3. THE PREMIUM FOR THE PARTICIPANT.

33 4. THE HEALTH REASON FOR WHICH THE INSURER REJECTED OR REFUSED
34 COVERAGE TO THE INDIVIDUAL.

35 D. THE POLICY, EVIDENCE OF COVERAGE OR SUBSCRIPTION CONTRACT ISSUED TO
36 A PARTICIPANT SHALL CLEARLY STATE THAT THE INSURER IS ADMINISTERING THE
37 COVERAGE FOR THE BOARD AND DISCLOSE THE TERMINATION PROVISIONS IN SECTION
38 36-3809.

39 E. ON ENROLLMENT, THE INSURER SHALL ISSUE THE PARTICIPANT A CARD
40 SHOWING ENROLLMENT IN THE PROGRAM. THE CARD SHALL CONTAIN THE PROGRAM NAME
41 AND SHALL CLEARLY STATE THAT THE INSURER IS ADMINISTERING THE COVERAGE FOR
42 THE BOARD.

43 F. THE INSURER SHALL USE THE SAME WELLNESS, DISEASE MANAGEMENT AND
44 CARE MANAGEMENT PROGRAMS THE INSURER CUSTOMARILY USES IN THE NORMAL COURSE OF
45 BUSINESS.

38-3808. Dependent coverage

AN INSURER MAY COVER DEPENDENTS ON A POLICY ISSUED PURSUANT TO THIS CHAPTER, BUT DEPENDENTS ON THE PARTICIPANT'S POLICY ARE NOT ELIGIBLE FOR THE HEALTHCARE GROUP HIGH RISK PROGRAM UNLESS THEY INDEPENDENTLY QUALIFY UNDER SECTION 36-3807. INSURERS SHALL NOT SUBMIT A DEPENDENT'S CLAIMS TO THE ADMINISTRATION FOR REIMBURSEMENT OF CLAIMS EXPENSES UNLESS THE DEPENDENT INDEPENDENTLY QUALIFIES FOR COVERAGE. AN INSURER MAY INDIVIDUALLY UNDERWRITE AND PRESCRIBE PREMIUMS FOR A DEPENDENT.

36-3809. Cessation of program benefits

A. AN INSURER SHALL TERMINATE PROGRAM COVERAGE ON BEHALF OF THE BOARD IF EITHER EVENT OCCURS:

1. THE PARTICIPANT FAILS TO PAY THE PREMIUM ACCORDING TO THE INSURER'S STANDARD REQUIREMENTS.

2. THE STATE FAILS TO FUND OR DISCONTINUES THE PROGRAM.

B. AN INSURER SHALL NOTIFY THE BOARD WITHIN FIVE DAYS OF TERMINATING COVERAGE UNDER THIS SECTION.

C. AN INSURER SHALL NOT SUBMIT A CLAIM FOR REIMBURSEMENT FOR AND THE ADMINISTRATION SHALL NOT REIMBURSE CLAIM EXPENSES THAT ARISE AFTER THE INDIVIDUAL'S INSURANCE POLICY TERMINATES.

36-3810. Premium rates; premium collection; administrative offset

A. THE BOARD SHALL DETERMINE THE PREMIUMS FOR AN INDIVIDUAL'S INSURANCE POLICY UNDERLYING THIS PROGRAM. THE PREMIUM SHALL RANGE FROM ONE HUNDRED FIFTY PER CENT TO TWO HUNDRED PER CENT OF THE STANDARD RATE FOR THAT PRODUCT.

B. NOTWITHSTANDING SUBSECTION A OF THIS SECTION, THE BOARD MAY DECLARE AN EMERGENCY PURSUANT TO SECTION 36-3812 AND INCREASE PREMIUMS ABOVE TWO HUNDRED PER CENT OF THE STANDARD RATE.

C. AN INSURER SHALL COLLECT THE PREMIUM FROM THE PARTICIPANT PURSUANT TO THE INSURER'S STANDARD PRACTICES. WITHIN FIVE DAYS AFTER RECEIVING THE PREMIUM, THE INSURER SHALL FORWARD THE PREMIUM TO THE BOARD, LESS TEN PER CENT FOR ADMINISTRATIVE EXPENSES. THE BOARD SHALL DEPOSIT PREMIUMS RECEIVED BY INSURERS IN THE HEALTHCARE GROUP HIGH RISK PROGRAM FUND ESTABLISHED BY SECTION 36-3814.

36-3811. Benefits

A. THE INSURER SHALL OFFER THE APPLICANT AT LEAST TWO DIFFERENT POLICY FORMS, BOTH OF WHICH ARE DESIGNED FOR AND MADE GENERALLY AVAILABLE AND ACTIVELY MARKETED TO BOTH ELIGIBLE AND OTHER INDIVIDUALS AND SHALL ENROLL AN ELIGIBLE INDIVIDUAL. THE OFFER SHALL INCLUDE AT LEAST THE POLICY FORMS WITH THE LARGEST AND NEXT TO THE LARGEST EARNED PREMIUM VOLUME OF ALL POLICY FORMS OFFERED BY THE INSURER IN THIS STATE IN THE INDIVIDUAL MARKET DURING A PERIOD THAT DOES NOT EXCEED THE PRECEDING TWO CALENDAR YEARS.

B. NOTWITHSTANDING SUBSECTION A, AN INSURER MAY ALSO OFFER A POLICY THAT MEETS THE FEDERAL HIGH DEDUCTIBLE REQUIREMENTS AND QUALIFIES AS A FEDERAL HEALTH SAVINGS ACCOUNT.

C. AN INSURER SHALL ANNUALLY PROVIDE DETAILS TO THE BOARD ON THE POLICIES THE INSURER OFFERS PURSUANT TO THIS SECTION.

36-3812. Balancing income and expenses

A. IF THE PROGRAM'S EXCESS PREMIUM TAX PROCEEDS PURSUANT TO SECTION 20-224, SUBSECTION F IN ANY FISCAL YEAR EXCEED THE PLAN'S ACTUAL LOSSES AND ADMINISTRATIVE EXPENSES, THE BOARD SHALL HOLD THE EXCESS IN AN INTEREST-BEARING ACCOUNT AND USE THE EXCESS TO OFFSET FUTURE LOSSES. FOR THE PURPOSES OF THIS SUBSECTION, "FUTURE LOSSES" INCLUDES RESERVES FOR INCURRED BUT NOT REPORTED CLAIMS.

B. THE BOARD SHALL OPERATE THE PROGRAM IN A MANNER SO THAT THE ESTIMATED COST OF REIMBURSING CLAIMS DURING ANY FISCAL YEAR DOES NOT EXCEED THE TOTAL INCOME THE PLAN EXPECTS TO RECEIVE FROM PREMIUM TAX DEPOSITS RECEIVED PURSUANT TO SECTION 20-224, SUBSECTION F AND PREMIUM RECEIVED PURSUANT TO SECTION 36-3810. THE BOARD SHALL ESTIMATE THE AMOUNT OF CLAIMS THE BOARD EXPECTS TO REIMBURSE EACH MONTH AND TRANSFER SUFFICIENT MONIES FROM THE HEALTHCARE GROUP HIGH RISK PROGRAM FUND ESTABLISHED BY SECTION 36-3814 TO THE HEALTHCARE GROUP CLAIMS REIMBURSEMENT FUND ESTABLISHED BY SECTION 36-3815.

C. IF THE BOARD DETERMINES THE PREMIUM TAX EXCESS DEPOSITS ARE INSUFFICIENT TO COVER CLAIMS REIMBURSEMENT COSTS, THE BOARD SHALL:

1. DECLARE AN EMERGENCY.

2. ORDER ALL INSURERS TO STOP ACCEPTING NEW BUSINESS UNDER THE PROGRAM.

3. REFUSE TO PAY CLAIMS FOR ANY NEW INDIVIDUALS WHO JOIN THE PROGRAM AFTER THE ORDER TO STOP ISSUING POLICIES.

4. INCREASE THE PREMIUM RATES TO AN ACTUARIALLY SOUND LEVEL THAT WILL MORE ADEQUATELY COVER COSTS.

36-3813. Claims payment; reimbursement

A. AN INSURER SHALL PAY A PARTICIPANT'S CLAIMS PURSUANT TO THE POLICY.

B. AFTER PAYING CLAIMS FOR PARTICIPANTS, THE INSURER SHALL SEND THE BOARD AN INVOICE EVERY TWO WEEKS REQUESTING REIMBURSEMENT FOR CLAIMS PAID DURING THAT PERIOD. THE INVOICE MUST CONTAIN DETAILS ABOUT EACH CLAIM PAID DURING THE TWO-WEEK PERIOD, INCLUDING THE PARTICIPANT NAME, IDENTIFICATION NUMBER, POLICY TYPE, DATE OF SERVICE, DATE AND AMOUNT PAID, TYPE OF SERVICE AND PROVIDER.

C. WITHIN FIVE DAYS AFTER RECEIPT OF THE CLAIM, THE BOARD SHALL REIMBURSE THE INSURER OR ISSUE A PARTIAL REIMBURSEMENT TO THE INSURER. IF THE BOARD ISSUES A PARTIAL REIMBURSEMENT, THE BOARD SHALL INDICATE WHICH CLAIMS THE BOARD MUST RESEARCH AND REQUEST FURTHER INFORMATION IF NEEDED. THE BOARD MUST DENY THE CLAIM, PROVIDING A DETAILED EXPLANATION AND AN OPPORTUNITY FOR RESUBMITTAL, OR PROPERLY PAY THE CLAIM WITHIN THIRTY DAYS AFTER INDICATING THE DELAY OR AFTER RECEIVING REQUESTED INFORMATION FROM THE INSURER, WHICHEVER IS LATER. THE BOARD SHALL DEVELOP A RESOLUTION PROCESS FOR CLAIM REIMBURSEMENT DISPUTES. AN INDEPENDENT ACTUARY SHALL RESOLVE ANY DISPUTES REGARDING THE DEFINITION OF STANDARD RATE TO LEVEL OF PREMIUM USED.

1 D. THE BOARD SHALL REIMBURSE CLAIMS OUT OF THE HEALTHCARE GROUP HIGH
2 RISK PROGRAM CLAIMS REIMBURSEMENT FUND ESTABLISHED BY SECTION 36-3815.

3 36-3814. Healthcare group high risk program fund; sources and
4 use of monies; investments

5 A. THE HEALTHCARE GROUP HIGH RISK PROGRAM FUND IS ESTABLISHED. THE
6 BOARD SHALL ADMINISTER THE FUND.

7 B. THE FUND CONSISTS OF MONIES RECEIVED FROM PREMIUMS PURSUANT TO
8 SECTION 36-3810 AND MONIES DEPOSITED PURSUANT TO SECTION 20-224,
9 SUBSECTION F.

10 C. THE BOARD MAY ACCEPT ANY GIFTS, GRANTS, DONATIONS OR APPROPRIATION
11 OF MONIES FROM ANY PRIVATE OR PUBLIC SOURCE.

12 D. THE BOARD SHALL WITHDRAW AND DEPOSIT MONIES IN THE FUND AS
13 NECESSARY TO OPERATE THE PLAN, INVEST PROCEEDS, ESTABLISH RESERVES AND PAY
14 CLAIMS, SALARIES AND OTHER EXPENSES OF THE PLAN.

15 E. ON NOTICE FROM THE BOARD, THE STATE TREASURER SHALL INVEST AND
16 DIVEST MONIES IN THE FUND AS PROVIDED BY SECTION 35-313, AND MONIES EARNED
17 FROM INVESTMENT SHALL BE CREDITED TO THE FUND.

18 36-3815. Healthcare group high risk program claims
19 reimbursement fund; sources and use of monies

20 A. THE HEALTHCARE GROUP HIGH RISK PROGRAM CLAIMS REIMBURSEMENT FUND IS
21 ESTABLISHED. THE BOARD SHALL ADMINISTER THE FUND.

22 B. THE FUND CONSISTS OF MONIES RECEIVED FROM THE HEALTHCARE GROUP HIGH
23 RISK PROGRAM FUND ESTABLISHED BY SECTION 36-3814.

24 C. THE BOARD SHALL WITHDRAW MONIES TO PAY CLAIMS PURSUANT TO SECTION
25 36-3813.

26 36-3816. Insurance producer and broker commissions

27 THE BOARD SHALL ESTABLISH MAXIMUM COMMISSIONS FOR PRODUCERS AND
28 DETERMINE WHETHER BROKERS ARE ENTITLED TO COMMISSIONS FOR RENEWALS OF PROGRAM
29 COVERAGE.

30 36-3817. Confidentiality

31 A. THE BOARD SHALL ENSURE THE CONFIDENTIALITY OF PARTICIPANTS'
32 PERSONALLY IDENTIFIABLE HEALTH INFORMATION.

33 B. THE BOARD SHALL ENSURE THE CONFIDENTIALITY OF INSURER COMPETITIVE
34 INFORMATION, INCLUDING CLAIMS, BENEFITS AND REIMBURSEMENT DATA.

35 36-3818. Program termination

36 THE HEALTHCARE GROUP HIGH RISK PROGRAM ESTABLISHED BY THIS CHAPTER ENDS
37 ON JANUARY 1, 2020 PURSUANT TO SECTION 41-3102.

38 Sec. 8. Section 43-210, Arizona Revised Statutes, is amended to read:

39 43-210. Premium tax credit; health insurance; certification of
40 qualified persons; violation; classification;
41 definitions

42 A. The department shall issue a certificate of eligibility to a person
43 who files an application with the department in the form and manner
44 prescribed by the department on a first come, first served basis, subject to
45 subsection E. An application submitted to the department under this section

1 shall contain or be verified by a written declaration that it is made under
 2 penalty of perjury. A person is entitled to receive a certificate if the
 3 department determines monies are available for this program pursuant to
 4 subsection E, the person has never before received a certificate and the
 5 person is ~~either~~ ONE OF THE FOLLOWING:

- 6 1. A small business.
- 7 2. An individual who satisfies all of the following:
 - 8 (a) Earns less than two hundred fifty per cent of the federal poverty
 9 level.
 - 10 (b) Is a legal resident of this state and a citizen of the United
 11 States or a legal resident alien.
 - 12 (c) Has not been covered under a health insurance policy for at least
 13 six consecutive months before the application.
 - 14 (d) Is not enrolled in the Arizona health care cost containment
 15 system, medicare or any other state or federal government health insurance
 16 program.

17 3. BEGINNING JANUARY 1, 2010, AN INDIVIDUAL WHO WAS ENROLLED IN
 18 HEALTHCARE GROUP OF ARIZONA ON JANUARY 1, 2010.

- 19 B. A health care insurer that enrolls an individual or small business
 20 certified pursuant to this section shall deduct the amount of the certificate
 21 from the premium.
- 22 C. For an individual, the amount of the certificate is the lesser of:
 - 23 1. One thousand dollars for coverage on a single person, five hundred
 24 dollars for coverage on a child or three thousand dollars for family
 25 coverage.
 - 26 2. Fifty per cent of the health insurance premium.
- 27 D. For a small business, the amount of the certificate is the lesser
 28 of:
 - 29 1. One thousand dollars for coverage on each single employee or three
 30 thousand dollars for each employee who elects family coverage.
 - 31 2. Fifty per cent of the health insurance premium.
- 32 E. A health care insurer that enrolls an individual or small business
 33 certified pursuant to this section shall notify the department of the
 34 enrollment and the amount of premium tax credit it intends to claim for the
 35 current calendar year no later than the fifteenth day of the month following
 36 commencement of coverage. The department shall not issue any certificates
 37 under this section that exceed in the aggregate a combined total of five
 38 million dollars in any calendar year.
- 39 F. The initial certificate is valid for a period of ninety days after
 40 the date the department issues the certificate. If the individual or small
 41 business obtains health care insurance within this period of time, the
 42 certificate is valid for one year from commencement of coverage.

G. Sixty days before the expiration of the certificate the department shall review the status of the individual or small business. If the individual or small business continues to meet the qualifications pursuant to subsection A, paragraph 1, ~~or~~ paragraph 2, subdivisions (a), (b) and (d) **OR PARAGRAPH 3**, the department shall reissue the certificate of eligibility.

H. Individuals and small businesses are eligible for a maximum of two reissued certificates of eligibility.

I. This section does not guarantee health insurance coverage to an individual or small business pursuant to this section.

J. The department shall issue the certificate of eligibility in the name of a specific individual, and the certificate is nontransferable. A person who sells, conveys, transfers or assigns the certificate to another person or attempts to sell, convey, transfer or assign the certificate to another person is guilty of a class 2 misdemeanor.

K. For the purposes of this section:

1. "Family" means any of the following:

(a) An adult and the adult's spouse.

(b) An adult, the adult's spouse and all unmarried dependent children under nineteen years of age or under twenty-five years of age if a full-time student.

(c) An adult and the adult's unmarried dependent children under nineteen years of age or under twenty-five years of age if a full-time student.

2. "Federal poverty level" means the federal poverty level guidelines published annually by the United States department of health and human services.

3. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation that provides health insurance in this state.

4. "Health insurance" means a licensed health care plan or arrangement that pays for or furnishes medical or health care services and that is issued by a health care insurer.

5. "Small business" means **EITHER:**

(a) A business that has been in existence for at least one calendar year in this state, that had not provided health insurance to its employees for at least six consecutive months before the application and that had at least two and no more than twenty-five employees during the most recent calendar year.

(b) **BEGINNING JANUARY 1, 2010, A SMALL GROUP OF TWO TO FIFTY EMPLOYEES, OTHER THAN A POLITICAL SUBDIVISION OF THIS STATE, THAT WAS ENROLLED IN HEALTHCARE GROUP OF ARIZONA AS OF JANUARY 1, 2010.**

Sec. 9. Delayed repeal

Sections 20-2330, 36-2912, 36-2912.01, 36-2912.02 and 36-2912.03, Arizona Revised Statutes, are repealed from and after June 30, 2010.

1 Sec. 10. Laws 2007, chapter 263, section 30 is amended to read:

2 Sec. 30. Healthcare group: temporary enrollment limit

3 Notwithstanding section 36-2912, Arizona Revised Statutes, beginning on
4 July 1, 2007 and ending ~~on the effective date of this act~~ FROM AND AFTER JUNE
5 30, 2010, healthcare group shall not enroll more than nine thousand eight
6 hundred employer groups defined as eligible pursuant to section 36-2901,
7 paragraph 6, subdivisions (b), (c), (d) and (e), Arizona Revised Statutes.

8 Sec. 11. Laws 2007, chapter 263, section 35 is amended to read:

9 Sec. 35. Delayed repeal

10 A. LAWS 2007, CHAPTER 263, sections ~~31, 32, AND 33 and 34 of this~~
11 ~~act~~, relating to healthcare group, are repealed from and after July 31, 2008.

12 B. LAWS 2007, CHAPTER 263, SECTIONS 31 AND 34, RELATING TO HEALTHCARE
13 GROUP, ARE REPEALED FROM AND AFTER JUNE 30, 2010.

14 Sec. 12. Initial terms of the healthcare group high risk
15 program board

16 A. Notwithstanding section 36-3804, Arizona Revised Statutes, as added
17 by this act, the initial terms of the voting members of the board of
18 directors of the healthcare group high risk program are:

- 19 1. One term ending January, 2012.
- 20 2. Two terms ending January, 2013.
- 21 3. Two terms ending January, 2014.
- 22 4. Two terms ending January, 2015

23 B. The governor shall make all subsequent appointments as prescribed
24 by statute.

25 Sec. 13. Healthcare group: contracts: renewal of contracts

26 Notwithstanding section 36-2912, Arizona Revised Statutes, beginning on
27 the effective date of this act, healthcare group shall not enter into any new
28 contracts and shall renew any existing contract only with a contract
29 termination date of before June 30, 2010.

30 Sec. 14. Temporary use of administration employees

31 The board of directors of the healthcare group high risk program may
32 use the services of the staff of the Arizona health care cost containment
33 system administration to assist with setting meetings, hiring staff and other
34 administrative tasks involved in establishing the healthcare group high risk
35 program. The board of directors shall compensate the administration for the
36 use of the employees.

37 Sec. 15. Effective dates

38 A. Title 36, chapter 38, Arizona Revised Statutes, as added by this
39 act, is effective from and after June 30, 2009.

40 B. Section 36-2930, Arizona Revised Statutes, as amended by this act,
41 is effective from and after June 30, 2010.

42 C. Sections 20-846, 20-1079 and 20-1383, Arizona Revised Statutes, as
43 added by this act, become effective from and after December 31, 2009.